



UNFOLDING THE STRENGTHS AND DIFFICULTIES AMONG CHILDREN-A STEP IN DETERMINING SCHOOL HEALTH

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ABSTRACT

Background: Child Mental Health is gaining a lot of importance in India today. Thanks to the contribution of research, education and media. However, adequate support and care needs to be extended to all children in this regard keeping in mind the unequal access and availability of resources owing to economic reasons. One of the attempts made to safeguard child health in Karnataka is through providing health services in schools. While it is important to prevent physical health issues, it poses a bigger challenge to understand the underlying mental health issues among children at an early stage. Hence the study is an attempt to know the Mental Health status of school going children in Bangalore as a base before launching a wider study of the sorts.

Aim: A baseline survey was conducted as an attempt to know the mental health of children of class 7 studying in the Government schools of Bangalore, India.

Method: Strengths and Difficulties questionnaire (SDQ) was administered on 90 children in the age group of 12 to 13 years studying in class 7 from three government schools across Bangalore. The questionnaire included sub scales namely emotional difficulties, Conduct difficulties, Hyperactivity, Peer problems and pro social behaviours.

Results: In the total difficulty score around 31% showed a difficulty level which is above average, about 29% showed difficulties at borderline level and the remaining 30% showed no difficulties at all. (Mode 17 with 5.09 standard deviation). Among them 46.7% had conduct difficulties and 28.9% of them had emotional difficulties. Chi-square test indicated that emotional status and conduct status are significantly associated ($p=0.013$).

Conclusion: It is evident that more than half of the population face some or the other forms of difficulties in their day to day life resulting in declined mental and social functioning. A comprehensive intervention needs to be planned to safeguard the psychological and social health of children in schools.

KEY WORDS: Strengths, difficulties, government schools.

INTRODUCTION:

In India, about 30.9% of the population consists of children belonging to the age group of 0-14 years. (Census 2011). Childhood is a stage where a child learns and develops various skills, behaviour and attitude through experiences which ultimately result in the formation of a personality. It is thus rightly called formative years as it has its bearing on the future abilities of a child in various walks of life. It is thus important to provide children with adequate care, support and necessary resources that aid their physical, mental and social development. Unfortunately, in many developing nations including India, the uneven distribution of resources and facilities makes it far from reality as many children and their parents from lower socio economic background have to strive hard to meet the ends.

In India, children who opt for schools run by Government are largely from families with lesser income. The Credit Suisse India Consumer Survey 2011 shows that income levels have a clear influence on the nature of school enrolment among households. It is worthy to mention that government school enrolment declines in higher income segments while the demand for English medium schools increases for the same income segment group. (British Council, India, 2014). The present study also focuses on such children studying in government schools since children in families with greater material resources enjoy more secure living conditions and greater access to a range of opportunities that are often unavailable to children from low-income families which often leads to poorer health outcomes. (SenGupta, De Wit, & Mc Keown, 2007).

Schools provide an ideal opportunity to monitor changes in student knowledge, attitudes and behaviour on an ongoing basis and have a long history as settings for health promotion. (Pan Canadian Joint Consortium for School Health, 2010.) Thus in order to facilitate healthy development of children from lower socio economic background, the state must plan and implement strategies in all government schools, also ensuring more equitable distribution of health services. The significance of mental health services needs to be highlighted in the overall health program in schools as children from lower socio economic background are more likely to suffer from various mental health issues. (Reiss, 2013).

When a child exhibits symptoms of somatisation in the form of fever or stomach pain, it can often be attributed to lack of encouragement at school or parents, fear of punishment, pressure to perform certain tasks or peer pressure. The presence of such anxieties, fear or any other mental illness in children, if not properly diagnosed and treated, increases the likelihood of significant health issues for them as adults and greatly limits their ability to become productive members of society (Wu et al, 2006). The first signs of mental illness or emotional distress in children

can emerge in the school environment. It's well known that mental health issues such as anxiety, depression, and family problems often are the root causes of poor academic performance, disciplinary issues, and truancy. (Richardson 2012). According to epidemiological studies in the United States, nearly 1 in every 10 children has a depressive episode before their 14th birthday. (Keyes 2006).

Keeping this in view, extensive effort needs to be made to assess the child's mental strengths and difficulties faced at an early stage as it constitutes an integral part of promoting mental health among school children through a systematic intervention. It is administered to children of 12 to 13 years as it is the transitional phase of attaining puberty which may pose a host of newer and additional challenges. Thus it is an attempt to know the need and scope for an intervention for mental health at the school level as part of school health in the government primary schools in Bangalore, Karnataka.

METHOD:

Sample:

The study was conducted on a group of 90 children who belonged to the age group of 12 to 13 years studying in 7 grade. The data was collected in 3 different government schools of Bangalore offering co-education. These three schools were selected randomly from the list of schools run by the Department of education, Block 3, Bangalore South. The list was provided in the official website of Department of Public Instruction. Written permission was obtained from the block Education officer. All the children who participated in the study. The sample was taken from classes with Kannada as the medium of instruction. Census method was used as there was only one section or class offering 7 grade. Each School had an average of 30 students in the class.

Measure:

Strengths and Difficulties questionnaire:

The study was done with the help of a scale called "Strengths and Difficulties questionnaire" (Youth in Mind.2010) that had five important domains namely emotional difficulties, conduct problems, difficulties with the peers, hyper activity and pro social behaviour. All these domains deal with the difficulties and strengths a child would have in day to day living. The scale assesses emotional problems, conduct problems, hyperactivity, peer problems, pro social behavior with 5 items each. It is that part which assesses the symptoms for mental health issues in children. The 25 items in the SDQ comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales first before working out the total difficulties score. 'Not True' was scored as '0', 'Somewhat True' is scored as 1 and 'Certainly True' is scored as 2. For each of the 5 scales the score can range from 0 to 10

if all items were completed.

Total difficulties score:

This is generated by summing scores from all the scales except the prosocial scale. The resultant score ranges from 0 to 40, and is counted as missing of one of the 4 component scores is missing. 'Externalising' and 'internalising' scores: The externalising score ranges from 0 to 20 and is the sum of the conduct and hyperactivity scales. The internalising score ranges from 0 to 20 and is the sum of the emotional and peer problems scales. Using these two amalgamated scales may be preferable to using the four separate scales in community samples, whereas using the four separate scales may add more value in high-risk samples.

Procedure:

The consent of teachers and parents were taken prior to the administration of the questionnaire. Once the consent was obtained, the Strengths and Difficulties Questionnaire was administered to all children in the class for self-assessment. The aim and objective of the study was mentioned to the participants. They were also reassured about confidentiality that would be maintained in the study. The researcher was also present in the class room during the self-assessment to clarify possible doubts in the questionnaire. The children were given adequate time and freedom to do a thorough self-evaluation based on the items given in the questionnaire.

Data Analysis:

Descriptive analysis was done for all the sub scales. SPSS 16 was used to score standard deviation and to draw inferential statistics.

RESULTS:

It is known that children experience a lot of emotional issues due to various reasons. The study reveals that more than half of the population has either borderline or above borderline level emotional issues.

Table 1: Types of difficulties faced by school children (N=90)

	Emotional problems	Conduct problems	Hyperactivity	Peer problems	Prosocial Behaviour
Normal	41 (45.6%)	29 (32.2%)	76 (84.4%)	31 (34.4%)	88 (97.8%)
Borderline	23 (25.6%)	19 (21.1%)	11 (12.2%)	36 (40%)	1 (1.1%)
Abnormal	26 (28.9%)	42 (46.7%)	3 (3.3%)	23 (25.6%)	1 (1.1%)

It is clearly seen in Table.1 that more than half of the population suffers from one or the other kind of conduct difficulties either at borderline or at an abnormal level. About 25.6% of the children have emotional problems at borderline level while 28% of them have at an abnormal level. Conduct problems at borderline and abnormal levels are expressed by 21.1% and 46.7% of children respectively. Majority (84.4%) of them seem to be free from the problem of hyperactivity as against peer problems at an abnormal level faced by 25.6% of them. About 97.8% of the children assessed themselves to be having a pro social behaviour.

Table 2: Emotional difficulties and conduct difficulties

Emotional difficulties	Conduct difficulties			Total
	Normal	Borderline	Abnormal	
Normal	20	9	12	41
	48.8%	22.0%	29.3%	100.0%
	69.0%	47.4%	28.6%	45.6%
Borderline	5	3	15	23
	21.7%	13.0%	65.2%	100.0%
	17.2%	15.8%	35.7%	25.6%
Abnormal	4	7	15	26
	15.4%	26.9%	57.7%	100.0%
	13.8%	36.8%	35.7%	28.9%
Total	29	19	42	90
	32.2%	21.1%	46.7%	100.0%
	100.0%	100.0%	100.0%	100.0%

Table 2 shows that half of the subjects (48.8%) with Normal emotional condition also had Normal conduct status, while majority of the subjects with Borderline emotional status (65.2%), as well as abnormal emotional status (57.7%) had abnormal conduct status. Chi-square test indicated that emotional status and conduct status are significantly associated ($p=0.013$).

It can be seen that majority of the subjects with Normal conduct status had Normal emotional status (20, 69%), while more than one-third of those subjects with Borderline or Abnormal conduct status had abnormal emotional status (37%, 36% respectively). Chi-square test indicated that emotional status and conduct status are significantly associated ($p=0.013$).

Table 3: Chi-Square Test

	Value	df	p-value (2-sided)
Pearson Chi-Square	12.732 ^a	4	.013
N of Valid Cases	90		

Table 4. Total Difficulties and gender (N=90)

Total difficulties	Gender		Total
	Male	Female	
Normal	17	13	30
	56.7%	43.3%	100.0%
	28.3%	43.3%	33.3%
Borderline	20	9	29
	69.0%	31.0%	100.0%
	33.3%	30.0%	32.2%
Abnormal	23	8	31
	74.2%	25.8%	100.0%
	38.3%	26.7%	34.4%
Total	60	30	90
	66.7%	33.3%	100.0%
	100.0%	100.0%	100.0%

Table 4 shows no significant difference between girls and boys in terms of strengths and difficulties. About 33.3% of the boys fall under borderline difficulties category as against girls with 30%. About 38.3% of boys and 26.7% of girls have difficulties at abnormal level. This is supported by the chi-square value being $p=.331$.

DISCUSSION:

The results indicate that school children have difficulties in managing their emotions, conduct and peer relations. While the attributes for these difficulties can be in families, schools or in the larger society, it is crucial to identify and provide them with appropriate interventions.

Findings emphasize the importance of a comprehensive screening program for school-aged children and the role that school teachers and counsellors/School social workers need to play through classroom observation in identifying early risk for mental health disorders. It is also important to note that results could inform school-based intervention or prevention programs targeting masked symptoms, an under-recognized area of children's mental health.

In the study more than half of the population exhibits one or the other mental health difficulties at border line (29%) and abnormal level (31%) respectively. As per research evidences, school children in India have behavioral and emotional problems in the range of 13.5% to 50%. (Khan & Khan, 2014). Huebner et al. (2000) found that 25 % of American students reported an 'unhappy' or 'terrible' existence, or high levels of negative school or family experiences. Rate of mental disorders tends to be similar in Israel. According to the Israel Survey of mental health, the prevalence of mental disorders among adolescents younger than 18 years is 11.7 % for any disorder, 8.1 % for internalizing disorders and 4.8 % for externalizing disorders (Farbstein et al. 2010).

While there are a number of reasons for the problem, all children, however, will have broadly similar basic needs from their schools—to be places in which their academic, physical, emotional, social, and moral development can progress. (Hargreaves 2003). Schools in several low and middle income countries have received significant Public health interventions. It is also proven that schools are potential medium through which efficient interventions can be made across health education sectors. (Fazel et al., 2014). They also go on to say that schools are a non-stigmatizing avenues for mental health promotion and intervention. However this is highly questionable as many parents refuse to accept any mental health issue in their child or access treatment. This, in such a case may come as a barrier for mental health promotion and intervention in schools. This needs to be viewed as a problem to encounter while any such program is planned as part of School Health promotion in India.

A new holistic approach to school health promotion was developed in the late 1980s, influenced and supported by the values set out in the World Health Organization's Ottawa Charter in 1986. (Langford R et al. 2014). This charter marked a significant shift in WHO public health policy, from a focus on individual behavior to recognition of the wider social, political, and environmental influences on health. This holds good in the current context of child mental health as it is a result of an interplay of various internal and external factors. Though WHO recommended that every country should have a National plan for child mental health in 1977, India is yet to draw out a program for Child and adolescent Mental Health. (Malhotra and Patra, 2014). The situation in Karnataka, which is one of

the states of India, is not very different. The schools here are provided with certain health services by the government like vaccination, fortified tablets, nutrition and regular health screening for major illnesses. (Ministry of Health and Family Welfare, 2016). The most important aspect to be questioned here is if these health services are succeeding in minimising the potential risk factors of both physical and mental illnesses in children. It is more likely to focus on physical disorders as they are “visible” and may inhibit the normal functioning of the individual depending on the nature of the illness. This may not be the case in mental or emotional issue in a child as this may not restrict the normal functioning like mobility or carrying out day today activities unless it takes the form of a major chronic disorder. It is also true that this “visibility” depends on awareness of parents and teachers on mental and emotional health issues.

CONCLUSION:

Considering that more than half of the sample population in the study exhibit mental health difficulties of one or more type either at a borderline or abnormal level, strategies need to be developed in this context to safeguard mental health in school children. An effective implementation with additional mental health services in the existing school health program can combat the problem. The study has limitations in terms of obtaining self-report from specific age group only. Multiple reporting with wider population will increase the possibility of generalisation.

REFERENCES:

1. British Council, India. (2014). Indian School Education Systems. New Delhi: British Council.
2. Farbstein, I., Mansbach-Kleinfeld, I., Levinson, D., Goodman, R., Levav, I., Vograft, I., et al. (2010). Prevalence and correlates of mental disorders in Israeli adolescents: Results from a national mental health survey. *Journal of Child Psychology and Psychiatry*, 51(5), 630–639.
3. Fazel, M., Patel, V., Thomas, S., & Tol, W. (2014). Mental Health Interventions in Low income and Middle income countries. *The Lancet Psychiatry*, 387–398.
4. Hargreaves, A. (2003). *Teaching in the knowledge society: Education in the age of insecurity*. New York: Teachers College Press.
5. Huebner, E. S., Drane, J. W., & Valois, R. F. (2000). Levels and demographic correlates of adolescent life satisfaction reports. *School Psychology International*, 21, 281–292.
6. Khan, M. A., & Khan, W. (2014). Multi Informant reporting of behavioural and emotional problems of School Students. *Delhi Psychiatry Journal*, 100–106.
7. Keyes, C. L. M. (2006). Mental health in adolescence: Is America's youth flourishing?. *The American Journal of Orthopsychiatry*, 76(3), 395–402.
8. Langford R, B. C. (2014). The WHO Health Promoting School framework for improving the health and wellbeing of students and their academic achievement (Review). (4). Retrieved 2016
9. Malhotra and Patra. (2014) Child and Adolescent Psychiatry and Mental Health. 8:22 <http://www.capmh.com/content/8/1/22>
10. Ministry of Health and Family Welfare. (2016, June). Rashtreya Bal Swasthya Karyakram. Retrieved from http://www.karnataka.gov.in/hfw/nhm/Pages/nbch_nbs_rbsk.aspx.
11. Office of the Registrar General and Census Commissioner, India. (2011, March 31). <http://pib.nic.in/prs/2011/latest31mar.pdf>. Retrieved from 00-003-2011-Cen-Data Sheet: <http://www.censusindia.gov.in/>
12. Pan Canadian Joint Consortium for School Health. (2010). Facilitating Health and Education Sector Collaboration in Support of Comprehensive School. *Canadian Journal of Public Health*, S18–S19.
13. Reiss F. Socio-economic inequalities and mental health problems in children and adolescents: A systematic review. *SocSci Med* 2013;90:24–31
14. Richardson, T., Morrisette, M., & Zucker, L. (2012). School based Adolescent Mental Health Programs. *Social Work Today*. 24.
15. Sen Gupta, R. P., De Wit, M. L., & Mc Keown, D. (2007, October). The impact of poverty on the current and future health status of children. *Pediatric Child Health*, 12(8), 667–672.
16. Wu, P. B. (2006). Childhood depressive symptoms and early onset of alcohol use. *Paediatrics*. 1907–191
17. Youth in Mind. (2010). Strengths and Difficulties Questionnaire (SDQ). Retrieved from <http://www.sdqinfo.com/a0.html>: <http://www.sdqinfo.com/>